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ABSTRACT

Designed to help alleviate some of the health problems among American Indians and Eskimos, this booklet covers suicide, homicide, and alcoholism. It can be used to provide: (1) "how-to" guidelines which describe ways for recognizing, handling, and preventing possible suicides among American Indians; and (2) survey data and literature for use as a planning guide in the development of crisis intervention and suicide prevention programs. Contents include: tribal and population data; Indian health problems; the current status of Indian suicide and alcoholism; old ways versus new: problems of transition; how to identify potential suicides; 10 preventive steps (suicide); ingredients of an Indian suicide prevention program; how to prevent suicide in jails; Indian homicide; Indian alcoholism; facts about alcohol; how dependency develops (alcohol); group resources for rehabilitation; multidisciplinary resources; incidence and severity of the Indian alcohol problem; alcoholism among young people; and causes of suicides related to alcoholism. The 6 recommendations cover workshops, information centers, teacher training, crisis intervention centers, newsletters, and audiovisual information. Appendices give population data and community mental health centers serving Indians and Eskimos. (KM)

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SUICIDE, HOMICIDE, and ALCOHOLISM among American Indians:

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Guidelines for Help

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PREFACE

This booklet has been written to provide usable information for a wide range of readers. The hope is that it will hold some interest for both professionals and nonprofessionals who wish to work in the area of crisis intervention, principally with alcoholic and suicidal persons.

This publication can be used in two ways: (1) to provide "how-to" guidelines which describe ways for recognizing, handling, and preventing possible suicides among American Indians—information that may be particularly useful to law enforcement personnel, who are often the first to come in contact with potential suicides; and (2) to provide survey data and literature for use as a planning guide in the development of crisis intervention and suicide prevention programs.

The work was prepared in response to an initial request from Bureau of Indian Affairs officials to equip criminal justice personnel to deal more effectively with problems of suicidal behavior and alcoholism among young American Indians. It became readily apparent that a series of workshops should be held that would include representatives from any legitimate group dealing with our Indian population. The most expedient procedure possible was to hold the workshops by and for Indian people themselves. Experts from the problem areas of interest were assembled with representatives from 76 Indian tribes at four locations over a 6-month period. To cover the western portion of the United States where suicide and alcoholism seemed most acute, the meetings were held at the following sites: Warm Springs, Oregon, August 1972; Aberdeen, South Dakota, September 1972; Albuquerque, New Mexico, November 1972; and Phoenix, Arizona, January 1973. Those attending included tribal law enforcement personnel, tribal judges, tribal council and health board members, nonreservation law enforcement officials, regional Indian Health Service personnel, local community mental health personnel, and local alcoholism counselors.

The workshops were organized and conducted by the National Congress of American Indians with staff assistance from the management consulting firm of Cresap, McCormick and Paget, Inc. Funding came from the Center for Studies of Crime and Delinquency of the National Institute of Mental Health and the National Institute on Alcohol Abuse and Alcoholism. The Bureau of Indian Affairs and the Indian Health Service paid transportation expenses for most participants and resource personnel from their agencies. Collaborative

support came from such agencies as the National Congress of Indian Opportunity and the U.S. Department of Justice.

Although many people were enormously helpful in contributing to the workshops and in indirectly supplying information for this booklet, some warrant special mention. Apart from my own previous work in the field, most of the material came from the Indian Health Service, the National Institute on Alcohol Abuse and Alcoholism, the HSMHA Employee Health Program on Alcoholism, and the four workshops already noted. If any of the resource persons who participated have not received appropriate acknowledgment for their excellent contributions, they may rest assured that the oversight has been entirely inadvertent. Special thanks are due Leo Vocu, NCAI executive director; Robert Hampton and Iris Kipnis of Cresap, McCormick and Paget, Inc.; Donald Swetter, M.D., chief, Medical Services Branch, IHS; Eugene Suarez, chief, Law and Order Division, BIA; Bert Eder, public health adviser, Indian Desk, NIAAA, and their respective staffs for solid support and direct effort in collating information and helping to produce effective workshops. Particular recognition must be given to Sue Guyon, Indian Health Service, and George Retholtz, Ph.D., director, HSMHA Employee Health Program on Alcoholism, for supplying invaluable consultation and assistance. I have drawn liberally on Indian Health Service data and literature and on some excellent material concerning alcoholism developed by Dr. Retholtz. Most deserving of all for helping to add more than a modicum of practicality, humility, and compassion to the entire effort are those whose heritage represents the essence of the very first American—the Indian—a truly noble figure in the history of man.

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Introduction

Good health has always been regarded as one of man's most prized possessions. "So long as you have your health" is a phrase that has long been common coin in many cultures throughout the world. This concept has now been extended considerably beyond the realm of physical health. Mental health, in its widest context, has become an increasingly important part of health care. Mental health disorders usually have identifiable behavior components and are entwined with sociological and cultural variables, all of which must be examined carefully to provide effective service. Specific health problems cause most of the deaths in certain age groups but vary among different cultures. Most deaths need not occur until relatively late in life. In the United States accidents constitute the first cause of death among persons of all ages and racial groups up to the age of 45 years. Suicide and homicide are among the leading causes of death, especially in the younger age groups. Such deaths occur needlessly and are usually predictable and preventable. These same prominent causes of death affect the American Indian population with astonishing frequency, although there are other fatal disorders that distinguish Indians from non-Indians in the early years of life—principally anemias, bronchitis, and asthma. They occur largely because of inadequate parental supervision, diets, and health care.

Suicide is a denial of man's primitive need for survival. From ancient times, unnatural and violent deaths such as suicide and homicide have been condemned on religious, moral, and legal grounds (Frederick 1972*b*). Suicide, in particular, was seen as a profane act against God in the Judeo-Christian sense, and in early Greece and Rome, a violation against the government because the person's body belonged to the state to be used for military or whatever other purposes rulers deemed necessary. The suicide's property was confiscated and his remains were thought to be contaminated. The body was buried at a crossroads at midnight with a stake driven through the heart. Until as recently as 1961 suicide was a felony at common law in England, and this legal precedent was carried into American law since it derived from the British legal system.

While in the past some Indian groups may not have placed the same proscription on suicide as most non-Indian cultures, today suicide is essentially taboo throughout the Western world. Nobody wants to die, although some persons have prepared themselves to pass on with dignity, if infirm or suffering from debilitating old age. Even those who die for altruistic causes would prefer not to. They would rather

conditions exist that do not impel them to such action. One way to bring dignity to people, even in death, is to discuss all aspects of it openly, including suicide.

Some Indian Tribal and Population Data

The American Indian needs to receive assistance and guidance so as to learn to help himself and make the most of available resources.

A discussion of some background data will help emphasize the nature and seriousness of Indian mental health problems.

The latest U.S. Census data show that there were 827,091 American Indians and Alaskan natives in the United States in 1970. Aleut and Eskimo people living in Alaska may not consider themselves Indians, since they are more directly of Oriental descent. In this work, however, the term "Indian" is intended to encompass both American Indians and Alaskan natives.

Indian people differ from many other minority groups in that they often maintain strong tribal ties and identities. There are 467 recognized Indian tribes and bands in the United States, with populations varying from less than 100 to 130,000 (Navajo). Recognition of an Indian tribe is generally based on the existence of a tribal government.

Appendix A shows population data for American Indians and Alaskan natives, by State, from both the 1960 and the 1970 Censuses.

A quarter of a century ago the Indian population dwindled dramatically, but today it is increasing at 3½ times the rate of the general population. The total Indian population was 551,669 in 1960, and by 1970 it had increased to 827,091. This increase of 275,422 in the total Indian population is attributable not only to net additional births and less infant mortality but also to the identification of individuals as Indians in the 1970 Census not so identified or recorded in the 1960 Census. Thus, the identified Indian population increased 50 percent during the 10 years, while the general population (including Indians) increased only 13 percent.

In 1970, the 10 States with the highest Indian population were, in descending order, Oklahoma (97,731), Arizona (95,812), California (91,018), New Mexico (72,788), Alaska (51,528), North Carolina (43,487), Washington (33,386), South Dakota (32,365), New York (28,330), and Montana (27,130). The total Indian populations in these 10 States was 573,575, which represented 70 percent of the Nation's total Indian population.

Indian Health Problems

Federal health services for American Indians began during the early part of the 19th century when Army physicians undertook the task of halting smallpox and other contagious diseases among Indian

tribes who lived near military posts. The current program grew out of later treaties that included several provisions for medical services (Indian Health Service 1973). In 1849 the Bureau of Indian Affairs changed its organizational affiliation from the War Department to the Department of the Interior, and in 1955 the health program was transferred to the Public Health Service, U.S. Department of Health, Education, and Welfare.

Health conditions among American Indians, in the main, are now estimated to be 20 to 25 years behind those of the general population. Although many of the Indians' basic health conditions have begun to show some improvement, due in large measure to services by various governmental agencies, the mental health problems remain severe and appear to be increasing. These are primarily suicide, homicide, alcoholism, and accidental deaths related to emotional difficulties.

About 435,000 American Indians from more than 250 tribes and some 53,000 Alaskan natives (Indians, Eskimos, and Aleuts) are eligible for health care assistance from the Federal Government. The majority of these people live on governmental Indian reservations in some 24 States, principally west of the Mississippi and in the remote villages of Alaska. By and large, they are isolated from non-Indian society and their incomes are among the lowest of any population group.

Indians, Eskimos, and Aleuts receive a wide range of preventive, rehabilitative, and treatment services, including public nursing, health education, and some psychological and psychiatric services (Indian Health Service 1972). Also provided are environmental health services, including the construction of water supply and waste disposal facilities and the training of personnel needed for their maintenance. The U.S. Indian Health Service is responsible for the operation of 51 hospitals whose number of beds range from six to 268, each with an outpatient section. Contractual arrangements are also made with non-Government hospitals and health specialists to help supply direct care. The acceptance and use of these hospital facilities, however, have required some orientation and education of the people. In some instances, even though hospitals have been available, the Indian population has not used them. More recently, however, there has been an increase in the use of these services, especially since 1955. Hospital admissions have more than doubled, from 50,000 to over 100,000 a year. The percentage of babies born in hospitals rather than in homes has increased from 82.2 to 98.6. Outpatient visits have increased almost five times, from 455,000 to 2,236,000 per year.

Helping the Indian with mental health services still remains a major task. While some facilities are supplied by the Indian Health Service, various community mental health centers (CMHC) administered by the National Institute of Mental Health are also available to

the Indian population, even though they have not been optimally utilized so far. A list of mental health centers for use by all who live in the service area may be seen in Appendix B. A CMHC in either a city or a rural area will serve all persons who live in the area, whether one can pay for such services or not. The centers listed in Appendix B are those that can help serve persons who live on reservations.

The Current Status of Indian Suicide and Alcoholism

For two decades suicide has ranked approximately 10th among the leading causes of death for all persons in the United States. It is the third primary cause of death among adults 15 to 24 years of age, and the fourth leading cause among all persons between 15 and 44 years of age (Public Health Service 1970). The United States population of over 200 million people has an annual suicide rate of 11.7 per 100,000, or more than 23,000 per year. The American Indian population has a suicide rate about *twice the national average*. Some Indian reservations have suicide rates at least five or six times that of the Nation, especially among younger age groups. These data are shown in Tables I, II, and III. While the national rate has changed but little over the last three decades, there has been a notable increase in suicide among Indians, especially in the younger age groups. Homicide and accidents also reveal particularly high death rates among various Indian groups.

Statistics about suicide among Indians reveal that 70 percent of all attempts are made by Indian females and 70 percent of all deaths resulting from suicide occur among Indian males. Three times as many females attempt suicide as males, and among those who commit suicide, men exceed women three to one, which is similar to that found in the general population (Frederick and Lague 1972*a*). Female suicide attempts are more often associated with depression, whereas male suicides appear to be related to alcoholism. Seventy-five to 80 percent of all suicides among Indians are alcohol-related, a rate which exceeds that of the general population two or three times over.

It should be noted that high suicide rates have not occurred universally in all American Indian cultures since the incidence is lower than average among some tribes. Nevertheless, it has become so severe in many tribes, particularly among the young, that it constitutes a major mental health problem.

Females usually use less violent methods of self-destruction such as drugs. Males tend to choose more violent methods such as hanging or shooting.

Over the last few years, the three rising causes of death have been related to self-destruction and alcoholism. By frequency they are cirrhosis of the liver, suicide, and homicide (National Center for Health Statistics 1972*a*, 1972*b*).

Table I—United States death rates for suicide and homicide among all races† 1940–1972

Year	Suicide	Homicide
1940	14.4	6.3
1941	12.8	6.0
1942	12.0	5.9
1943	10.2	5.1
1944	10.0	5.0
1945	11.2	5.7
1946	11.5	6.4
1947	11.5	6.1
1948	11.2	5.9
1949	11.4	5.4
1950	11.4	5.3
1951	10.4	4.9
1952	10.0	5.2
1953	10.1	4.8
1954	10.1	4.8
1955	10.2	4.5
1956	10.0	4.6
1957	9.8	4.5
1958	10.7	4.5
1959	10.6	4.6
1960	10.6	4.7
1961	10.4	4.7
1962	10.9	4.8
1963	11.0	4.9
1964	10.8	5.1
1965	11.1	5.5
1966	10.9	5.9
1967	10.8	6.8
1968	10.7	7.3
1969	11.1	7.7
1970	*11.1	7.8
1971	*11.1	8.5
1972	*11.7	*9.1

†Per 100,000 population yearly.
*Provisional data based upon 10% sample.

SOURCES:
National Center for Health Statistics
Mortality Statistics Branch and
Uniform Crime Reports
U.S. Department of Justice

The leading cause of death for all races in the United States is cardiovascular illness, the second is cancer, and the third is accidents (many of which could be attributed to alcoholism or be self-destructive in nature). Suicidal deaths now rank about 10th among the leading causes of death in the United States.

Suicide can be defined as any human act intentionally designed to bring about the end of one's life. Deaths may be classified as intentional, unintentional, and subintentional (Shneidman 1967). The definition of an intentional death is self-explanatory. An example of an unintentional death might be a brick falling from a building and striking a passerby. A subintentional death is the psychological equivalent of suicide, an example being drinking or eating oneself to death.

Table II.—Suicide deaths and rates per 100,000 population for Indians and Alaskan Natives in 24 reservation States and for United States, all races, 1959–1971*

Year	Number		Crude Rates [1]		Age Adjusted Rates [1]		
	Indian and Alaskan Native	U.S.; All races	Indian and Alaskan Native	U.S.; All races	Indian and Alaskan Native [2]	U.S.; All races	Ratio of Indian to U.S.; All races
1971	135	NA	18.7	[2] 11.1	21.8	[2] 11.3	1.9
1970	NA		NA		NA		
1969	94	22,364	13.8	11.1	16.8	11.3	1.5
1968	90	21,372	14.0	10.7	17.5	11.0	1.6
1967	94	21,325	12.9	10.8	16.2	11.1	1.5
1966	64	21,281	12.0	10.9	15.2	11.2	1.4
1965	65	21,507	10.1	11.1	12.9	11.4	1.1
1964	52	20,588	11.6	10.8	15.8	11.0	1.4
1963	66	20,825	11.4	11.0	15.6	11.3	1.4
1962	59	20,207	12.1	10.9	16.9	11.1	1.5
1961	61	18,999	11.7	10.4	16.7	10.5	1.6
1960	57	19,041	11.7	10.6	16.8	10.6	1.6
1959	57	18,633	11.7	10.6	17.0	10.6	1.6

1. Indian and Alaskan Native rates are three year rates through 1968. All other rates are based on single year data.
2. Provisional—Monthly Vital Statistics Report.

*Data supplied by the Indian Health Service, U.S. Department of Health, Education, and Welfare.

Table III.—Age specific suicide death rates* per 100,000 population for Indian and non-Indian groups

CY—1968

Age at death	Indian and Alaskan Native	U.S. all races	U.S. white	U.S. nonwhite	Ratio of Indian to U.S. all races	Ratio of Indian to U.S. nonwhite
All Ages.....	16.3	10.7	11.5	4.8	1 5	3.4
5–14.....	1.8	0.3	0.3	0.1	6.0	18.0
15–24.....	35.0	7.1	7.3	5.6	4.9	6.3
25–34.....	39.2	12.1	12.3	10.0	3.2	3.9
35–44.....	20.1	16.2	17.2	8.2	1.2	2.5
45–54.....	12.3	19.6	20.9	7.7	0.6	1.6
55–64.....	13.8	21.8	23.2	7.4	0.6	1.9
65.....	13.5	20.8	22.2	6.5	0.6	1.2

*Average—1969 and 1971.
Adapted from data supplied by the Indian Health Service, U.S. Department of Health, Education, and Welfare.

Subintentional death probably accounts for the largest number of deaths, even though they are not reported as such. This category takes into account all kinds of other deaths in which the degree of intent is uncertain, such as accidents or not caring for one's health when a known infirmity exists.

Self-destructive behavior can be understood more fully if viewed as a continuum:

self-assaultive — self-destructive — suicidal

Self-assaultive behavior is that in which an individual abuses himself, but without full awareness of its life-threatening aspects. Self-destructive behavior occurs when an individual has known physical problems and takes no measures to care for himself. An example would be smoking when one has emphysema. Suicidal behavior involves an overt suicidal act with a relatively clear plan and intent.

Suicides are caused by loneliness, helplessness, and hopelessness. Everyone experiences one or two of these feelings occasionally, but when all three occur simultaneously the probability of a suicidal crisis greatly increases.

Old Ways Versus New: Problems of Transition

Shall I live in the white man's world or in the world of the Indian? That is a question every young Indian asks himself, but it is a problem far more complex than appears on the surface. Many Indians are isolated, present-day transportation facilities notwithstanding. Some live in or near communities on the reservation or in surrounding rural

areas. Although others live near cities, they seldom participate in the economic and political affairs of their communities.

As Curlee (1969) has observed, there is essentially no industry on the Cheyenne River Reservation, and the same situation exists on many other reservations. Most of the Indians' jobs are ephemeral or seasonal, and there is little work during the winter months. Thus, the Indian is forced to leave the reservation to search for a job or to accept low-paying jobs at home or welfare. By remaining on the reservation, he is likely to become trapped in an insidious net of dependency which denies him the pride and satisfaction of self-reliance. Many of these problems are central to Indians in every tribe, not merely those from the Cheyenne River Reservation.

If the Indian chooses to leave the reservation, he gives up the psychological security of known surroundings for an unfamiliar world for which he is totally unprepared. Skills and experience required to function in a new job in a strange setting are missing. Loneliness and isolation undermine confidence needed for success. The Indian feels unable to compete equally with non-Indians, and the sense of inferiority he has absorbed limits his motivation. Both the condescending attitudes of whites toward the Indians, and his own low self-esteem nurture and perpetuate a feeling of inadequacy.

Among the various behaviors that are psychological equivalents of suicide are perpetual disregard for proper care of one's health; aggressive acts toward others, which create hazardous situations; drug abuse; alcoholism, and reckless driving—all of which constitute risk-taking behavior. These other forms of self-destructive behavior are mentioned because their motivation resembles that of the overt suicide.

It is difficult to estimate the number of suicide attempts that are not reported, but the author believes it is as much as 40 to 50 times the reported number of actual committed cases (Frederick et al. 1973). On the Cheyenne River Reservation in one year 87 percent of the attempters were between the ages of 15 and 21. Seventy-seven percent were girls. One can thus see why prevention is now youth-centered.

A gnawing problem is the conflict of cultural transition. A clear modification in the old Indian value system has occurred. Although some of the older people have retained their identity with former Indian ways and received stability from them, the younger Indian finds it difficult to adhere to such values and customs. The Indian style of life itself has changed. Moreover, the young Indian inadvertently absorbs some of the ways of the white world. The two life styles do not always merge, helping lacunae and conflicts to appear. Young Indians grow up without a satisfactory identification either with their own heritage or with that of white society (Resnik and Dizmang 1971).

Cultural transition also makes it difficult for the young Indian to

know how to handle the temptations and stresses of entry into adult life. As the ways of his parents do not always square with his own situation, the younger Indian is unable to use his parents' behavior as a model for managing a stressful situation. The older method of teaching children by example often does not suffice. Many young suicide attempters have missed direction and guidance by their parents. This has deprived them of the sense of security that comes from a structured world and stable guideposts.

Allied with the notion of child instruction by example is a deep regard for individual autonomy, even to the point of allowing a youngster to make his own decisions about school attendance and medical care, as Curlee notes. This dates from the time when expected roles were well defined in the tribe, so that the child became socialized by observing the available models of behavior and through imitation. With changing times, some children often exploit missing authority to make demands upon adults. No frustration tolerance is learned in this manner. Those attempting suicide later verbalize the feeling that they were given their way too often, which results in demanding, self-centered, and immature behavior in which other people become objects to be manipulated. Thus, no mechanism is learned to withstand psychological stress, and there is a lack of ability to manage one's own impulses or to accept limitations imposed upon them.

Evident in most instances is an extremely low self-esteem with the belief that parents and others do not care for them. Since they feel that no one else values them, they see themselves as valueless.

Low self-esteem is also apparent among the older people, though associated more with alcoholism and violence in this group than with suicides. The man over 30 shows a lack of any kind of lasting ego satisfaction. His inability to be the breadwinner for the family, the fact that the mother and grandmother are the important teachers and disciplinarians of the youngsters, his inability even to father children when the mother chooses birth control measures without consulting him, his dependence on welfare and others to provide family services—all combine to preclude a feeling of self-satisfaction and personal worth. Besides adding to his futility, the Indian man's feeling of uselessness and dependency produce increased resentment and the need for some form of escape. Although providing a temporary release, alcohol only makes his problems worse later. It may then be relied on because of the initial diminution in tension, but the sequelae produce more problems from which relief is again sought and so a vicious cycle is created.

Curlee noted further that in almost every case of suicide and violence related to alcohol use the Indian would internalize all pain, anger, and worry until the emotional pressure became so great that some problem would evoke a response completely out of proportion to

the incident that caused it. The people Curlee studied often gave the impression that they were well adjusted and free of inner tension until the pressure became so great that it could not be withheld. This phenomenon appears in drinking and violence, when a person who is very staid while sober becomes abusive and brutal after ingesting alcohol.

Many reservation Indians involved in suicide episodes fit the traditional picture of the Indian as one who endures great pain without crying out, at least until the pain becomes unbearable. The actual suicide attempt is a manifestation of aggression turned inward, just as drinking and fighting provide a vehicle for the aggression. The suicidal act is frequently directed symbolically toward another person as a means of hurting him by producing feelings of guilt about the way he treated the victim.

How To Identify Potential Suicides

The Indian most inclined toward a completed suicide has the following social characteristics:

- He is a male between 15 and 24 years of age.
- He is single.
- He is under the influence of alcohol just before his suicide attempt.
- He has lived with a number of ineffective or inappropriate parental substitutes because of family disruption.
- He has spent time in boarding schools and has been moved from one to another.
- He has been raised by caretakers who have come into conflict with the law.
- He has often been jailed at an early age.
- He has experienced an emotional loss, such as divorce, desertion, or death in the family.
- He has experienced a past loss through violence of someone to whom he felt attached.

Research conducted on one reservation in the Northwestern United States revealed several clues to the identification of the suicidal individual (Pambrun 1972). He is the product of an unwanted pregnancy; he is a problem child as a preschooler; he is the middle child in the family; he has been given much freedom and little responsibility; he is not a member of the hardcore poverty class, but rather in a class slightly above the poverty level; he is an individual for whom unattainable goals and expectations have been set.

Numerous contributing factors are apparent in self-destructive behavior, but the experience of a loss continues to be a pervasive theme.

These losses include those which are internal, such as loss of self-esteem, loss of confidence, or loss of face resulting in humiliation. Then there are external losses which evoke self-destructive thoughts such as loss of a job, loss of standing in school, or loss of a loved friend or relative.

One may say that feelings of inferiority were present early in life and many Indians never had these traits to begin with, yet the small amount of personal well-being that was present has been lost, thereby precipitating a life-threatening crisis.

Behavioral clues that may aid in identification may be either overt or covert. Overt behavioral clues include actions such as the purchase of rope, guns, or pills. Covert behavioral clues are clinical depression, loss of appetite, loss of weight, insomnia, disturbed sleep patterns, fatigue or loss of energy, isolated behavior, changes in mood, and increased irritability. Signs of deterioration in behavior may also be observed; these include a sudden change of behavior in the school, home, or neighborhood, sudden frequency of law violations, and sudden use of alcohol, drugs, or sniffing of glue or gasoline.

Symptoms of depression are not always strikingly apparent, especially among youth. While depressive signs often do appear, the youngster may not have all the classical signs of a depression. It is a mistake to feel that an individual will not take his life unless he is clinically depressed. Adult depression and youthful depression do not always resemble each other. Behavior patterns to look for in potentially self-destructive youth include the following (Frederick 1970):

- Adolescents contemplating suicide are apt to have little verbal communication with their parents. This, in fact, is part of the problem. They are more likely to communicate with a peer or another interested individual in whom they have some faith and trust. Thus, if it is apparent that a youth cannot talk to his parents, the listener should be alert to the nuances of serious problems.
- Behaviorally, they are likely to give other signs which are a cause for concern. They may give away a prized possession with the comment that he or she will not be needing it any longer.
- The individual is apt to be more morose and isolated than usual.
- Young males are likely to have experienced the loss of a father or a close male figure through death or divorce before the age of 16 years.
- Girls who attempt suicide are likely to show much difficulty with their mothers, especially when there is a weak and ineffectual father figure. The girl often turns to a boy friend for support and he in turn lets her down because he is not capable of satisfying her psychological demands. Frequently, the girl may believe she is pregnant.

- Adolescents are apt to smoke heavily, suggesting the presence of severe tension or anxiety.
- General efficiency and school work performance may decline markedly.
- Involvement with various kinds of drugs or alcohol has accompanied anxiety, depression, and self-destruction.
- Even though apparently "accidental," one should be alert to instances of prior self-poisoning behavior. The same youngster who tries to kill himself will frequently have a history of self-poisoning, often requiring lavage. Ultimately, this behavior will result in self-destruction.
- Homes in which the professional suspects child-abuse or finds the so-called "battered child" syndrome are cause for serious concern, since there is a mounting body of clinical evidence to indicate that future violence, including suicide, may evolve from abuse in childhood. If the child feels openly rejected by his parents, this feeling should be noted, even if severe physical punishment is absent.
- It may be helpful to look for something in the youngster's behavior or talk suggesting that he wants to get even with his parents. A prominent component in suicidal behavior is the wish to take one's own life in order to make those left behind sorry that they did not treat the victim better when he was alive.

Verbal clues also exist and may take three forms: (1) talking about another individual's suicide problems; (2) talking or inquiring about the hereafter, usually referring to a third person; and (3) talking about legal matters such as the disposal of property or the preparation of documents such as insurance policies or wills.

Ten Preventive Steps

The following are 10 preventive steps for the professional dealing with the suicidal patient:

- **Step 1: Listen**

  The first thing a patient in a mental crisis needs is someone who will listen and really hear what he is saying. Every effort should be made to really understand the feelings behind the words.

- **Step 2: Evaluate the seriousness of the suicidal patient's thoughts and feelings.**

  All suicidal talk should be taken seriously. If the patient has made definite plans, however, the problem is apt to be more acute than when his thinking is less definite.

- **Step 3: Evaluate the intensity or severity of the emotional disturbance.**
  It is possible that the patient may be extremely upset but not suicidal. If a person has been depressed and then becomes agitated and moves about restlessly, it is cause for alarm.
- **Step 4: Take every complaint and feeling the patient expresses seriously.**
  Do not dismiss or undervalue what the person is saying. In some instances the person may express his difficulty in a low key, but beneath his seeming calm may be profoundly distressed feelings.
- **Step 5: Do not be afraid to ask directly if the individual has entertained thoughts of suicide.**
  Suicide may be suggested but not openly mentioned in the crisis period. Experience shows that harm is rarely done by inquiring directly into such thoughts. As a matter of fact, the individual frequently welcomes it and is glad the therapist or counselor enables him to open up and bring it out.
- **Step 6: Do not be misled by the suicidal person's comments that he is all right and past his crisis.**
  Often the person will feel initial relief after talking of suicide, but many times on second thought, he will try to cover it up. The same thinking will come back later, however. Followup is crucial to insure a good treatment program.
- **Step 7: Be affirmative but supportive.**
  Strong, stable guideposts are extremely necessary in the life of a distressed individual. In other words, provide him with some strength by giving him the impression that you know what you are doing and that you intend to do everything possible to prevent him from taking his life.
- **Step 8: Evaluate the resources available.**
  The individual may have both inner psychological resources, such as various mechanisms for rationalization and intellectualization which can be strengthened and supported, and outer resources in his environment, such as ministers, relatives, and others whom one can call in. If these are absent, the problem is much more serious. Careful observation and support are necessary.
- **Step 9: Act specifically.**
  Do something tangible; that is, give the patient something definite to hang onto, such as arranging for him to see

someone else. Nothing is more frustrating to the patient than to leave the counselor's office and feel as though he had received nothing from the interview.

- **Step 10: Do not be afraid to ask for assistance and consultation.** Call upon whomever is needed, depending upon the severity of the case. Do not try to handle everything alone. Convey an attitude of firmness and composure to the person so that he will feel something realistic and appropriate is being done to help him.

Additional preventive techniques for dealing with persons in a suicide crisis include the following (Frederick 1973; Bergman 1972):

- Have a receptive individual stay with the person during the acute crisis.
- Do not treat the person with horror or deny his attempt.
- Make the environment as safe and provocation free as possible.
- Never challenge the person in an attempt to shock him.
- Do not try to win arguments about suicide. They cannot be won.
- Offer support.
- Give reassurance that his state of depression is temporary and will pass.
- Mention that if the choice is to die, the decision can never be reversed.
- Point out that while life exists there is always a chance for help and resolution of the problems, but that death is final.
- Focus upon survivors by reminding the person about the rights of others.
  - He will leave a stigma on his family.
  - He will predispose his children to emotional problems or suicide.
- Call in family and friends in the early stages to help establish a lifeline.
- Allow the patient to ventilate his feelings.
- Do not leave the person isolated or unobserved for any appreciable time.

Ingredients of an Indian Suicide Prevention Program

A suicide prevention program should contain the following ingredients (Shore et al. 1972; Shore 1972):

- Have broadly based community support, beginning with the Indian tribal council.
- Use active Indian counselors.

- Involve law enforcement officers who are capable of identifying high-risk persons and who can provide alternatives to incarceration for suicidal individuals.
- Have a crisis intervention program available 24 hours a day, with professional consultation and backup.
- Create vocational rehabilitation centers for high-risk communities.
- Try to secure housing and employment for those in need, especially on high-risk reservations.

Such a comprehensive approach requires that community services unite in an interdisciplinary effort to reduce suicide.

How To Prevent Suicide in Jails

Nearly all suicides in jails are alcohol-related. Suicides are most likely to occur during the detoxification period in the alcoholism cycle. Predictive information should be known by every law enforcement officer. Certain characteristics that distinguish juvenile attempts from adult attempts have been determined. Juveniles are apt to make impulsive, spur-of-the-moment attempts; whereas adults, even when intoxicated, often use planned and detailed methods. Police and jailers should not attempt to distinguish between so-called "gestures" and real attempts, but should consider any intoxicated and incarcerated person a potential suicide.

Basic preventive procedures which should be taken in jails include the following (Marble 1972):

- Belts, shoe strings, and ties should be removed from the inmate.
- Law enforcement personnel should be alert to the potential use of clothing or bed coverings as substitutes for rope.
- Medicine should be controlled by those in charge of the inmates.
- Guards or officers should be the main point of primary intervention with regular professional consultation.
- Intoxicated individuals should be placed in special holding quarters.

Personal welfare of the inmate should be the watchword of care. Officials should be careful not to degrade the inmate in any manner. A dehumanizing act by a guard can precipitate a crisis. The primary concern must be observation. Cells must be arranged so that observation is readily possible, which precludes solid doors. Closed-circuit television, if used, should cover the entire cell area. Certain considerations such as the time it takes a jailer to reach the cell should be taken into account. One must guard against using closed-circuit television as an alternative to help, since most potential suicides are "crying" for help and need personal contact.

Safeproofing of jail cells is of prime importance. The following basic procedures should be followed:

- Overhead bars or projections should be eliminated.
- Steel plates with very small holes should be used.
- Bed covering should not be permitted in the tank areas.
- Air conditioners should be used to add to personal comfort.

In addition to physical environment, the psychological environment is even more important. This takes into consideration each attitude displayed by policemen and jailers. *Nothing can take the place of personal contact and understanding in times of crisis.*

Indian Homicide

While the suicide rate has remained relatively constant over the last 30 years for the Nation as a whole, the homicide rate began to show a steady rise in the early sixties which has continued to the present, with an all-time high of 9.1 murders per 100,000 population in 1972 as shown in Table I. Since 1963 the national homicide rate has increased by 85 percent. The ratio of Indian homicides to that of all races, as shown in Table IV, has declined slightly over the last decade but the Indian rate is still almost three times the national average. As might be expected, it is highest among the 25-to-34-year age group, reaching a peak of over 55 per 100,000 population. This exceeds the next closest age range by at least a third and is more than twice as high as the rate in the other age ranges.

Although homicide is a serious problem among the American Indians, their rate is considerably less than that for the total United States nonwhite population, as may be seen from the data in Table V. Suicide constitutes a much greater problem among the Indian population than homicide, especially among the younger age groups, as a comparison of Tables III and V illustrates. This supports the notion that the psychological makeup of the Indian motivates him to become more self-destructive than destructive toward others. Having been taught to bear difficulty without wincing, he is more stoical than aggressive or belligerent—qualities that are sometimes attributed to him. Since alcohol acts as an irritating stimulant as well as a depressant, it is not surprising that the frustrations operating and fluctuating at various points in time can help evoke both suicidal and homicidal reactions. For many Indians, either drunk or sober, suicide is a likely response to stress but homicide is more likely to occur when the person is under the influence of alcohol than when sober. Attention has not been given to ferreting out specific causes and predictors of homicide to the same extent as for suicide, but it is clear that family quarrels, frustrations stemming from poor jobs, and alcoholism are contributing factors.

Table IV.—Homicide deaths and rates per 100,000 population for Indians and Alaskan Natives in 24 reservation States and for United States, all races, 1959–1971 *

Year	Number		Crude Rates [1]		Age Adjusted Rates [1]		Ratio of Indian to U.S.; All races
	Indian and Alaskan Native	U.S.; All races	Indian and Alaskan Native [2]	U.S.; All races	Indian and Alaskan Native [2]	U.S.; All races	
1971	149	[2] 17,580	20.6	[2] 8.5	26.4	NA	
1970	NA	[1] 15,610	NA	7.8	NA	NA	
1969	132	15,477	19.4	7.7	23.4	8.6	2.7
1968	116	14,686	18.1	7.3	22.2	8.2	2.7
1967	110	13,425	15.9	6.8	20.3	7.7	2.6
1966	79	11,606	15.7	5.9	20.3	6.7	3.0
1965	102	10,712	14.7	5.5	19.7	6.3	3.1
1964	84	9,814	17.1	5.1	23.6	5.8	4.1
1963	85	9,225	16.0	4.9	22.3	5.5	4.1
1962	80	9,013	14.8	4.8	21.0	5.5	3.8
1961	63	8,578	14.7	4.7	20.9	5.3	3.9
1960	80	8,464	13.7	4.7	19.5	5.3	3.7
1959	62	8,159	14.5	4.6	20.5	5.1	4.0

1. Indian and Alaskan Native rates are three year rates through 1968. All other rates are based on single year data.
2. Provisional—Monthly Vital Statistics Report.
*Data supplied by the Indian Health Service, U.S. Department of Health, Education, and Welfare.

Table V.—Age specific homicide death rates* per 100,000 population for Indian and non-Indian groups
CY—1968

Age at death	Indian and Alaskan Native	U.S. all races	U.S. white	U.S. nonwhite	Ratio of Indian to U.S. all races	Ratio of Indian to U.S. nonwhite
All ages.....	20.0	7.3	3.9	32.4	2.7	0.6
5–14.....	0.5	0.7	0.5	2.1	0.7	0.2
15–24.....	28.1	10.1	4.8	45.9	2.8	0.6
25–34.....	55.3	15.3	6.9	78.1	3.6	0.7
35–44.....	34.3	12.9	6.3	65.2	2.7	0.5
45–54.....	21.7	9.0	5.0	45.4	2.4	0.5
55–64.....	21.4	6.3	4.0	29.5	3.4	0.7
65.....	10.5	4.1	3.2	14.8	2.6	0.7

*Average—1969 and 1971.
Data supplied by the Indian Health Service, U.S. Department of Health, Education, and Welfare.

Data from 1971 show that Indians accounted for 0.4 percent of all crimes of violence (murder, forcible rape, robbery, and aggravated assault), which is their same percentage in the total urban population. The figure was higher in rural areas, where Indians comprised 3.2 percent of the total population, while their quota of violent crimes was recorded at 4.2 percent. Other nonwhite groups were notably higher in both urban and rural areas, however. Whites characteristically commit fewer violent crimes in relation to their proportion in the general population, but they are responsible for more crimes against property such as embezzlement and vandalism, depending upon age level.

In the general population, homicide is both premeditatedly and impulsively committed. Among the Indian people it is rarely planned but occurs almost entirely as a result of brawls while drinking or during arguments at home. Persons with long-standing personality disorders or so-called psychopathic personality types who are irresponsible, hedonistic, or conniving and are responsible for some murders in society at large are not usually found among the Indian tribes. The presence among Indians of early signs of severe mental disturbances such as the schizophrenic reactions requires much more research. Answers to questions about homicidal behavior as well as definitive clues to its prevention comprise a relatively unexplored area for research investigators. It is hoped that the future will yield more results, especially in view of the present emphasis upon law and order and crime and delinquency at Federal and local levels.

Indian Alcoholism

Alcoholism is the number one drug problem in the entire country and the fourth-ranking health problem in America today. Ninety-five

million Americans consume alcohol, and at least 10 percent (or nearly 10 million) are thought to have alcoholic problems. The Indian Health Service believes that no other condition adversely effects so many aspects of Indian life in the United States. The highest priority has been given at all levels to comprehensive alcoholism treatment and prevention by the Indian Health Service (Indian Health Service 1972*a*). Alcoholism has been defined as "a disease, or disordered behavior, characterized by repeated drinking of alcoholic beverages, which interferes with the drinker's health, interpersonal relationships or economic functioning." This definition encompasses the total range of behavior from alcoholic dependence through what might be termed problem drinking to repeated simple intoxication, with the provision that health, family and other social relations, or economic functioning become impaired as a result. Alcoholism may be considered both a disease and a behavioral disorder.

Facts About Alcohol

Ethyl alcohol, the intoxicating substance in the alcoholic beverages we drink, is a colorless, inflammable liquid, a chemical compound (C_2H_5OH), and a food (it supplies calories, but has no nutritive value) (Retholtz 1973). From a medical and physiological point of view it is an irritant, an antiseptic, a drying agent, a sedative, an anesthetic, and a hypnotic agent. It is an analgesic which, unlike other analgesics such as aspirin, reduces pain by putting the brain to sleep. Ethyl alcohol is also a craving-producing, habit-forming, and potentially addictive and poisonous narcotic drug. It is considered a drug because of its profound effects on the central nervous system. Alcohol is a liquid that diffuses rapidly in water as well as fatty substances. Its chemical structure is simple, allowing it to be readily metabolized. Hence, it can be easily incorporated into living cells, organs, and systems affecting all areas of activity within the human organism—biochemical, metabolic, physiological, and behavioral.

After alcohol is ingested, it passes through the stomach and into the small intestine where most of it is absorbed directly into the bloodstream without the need for digestion. Once in the bloodstream, alcohol begins to affect the interrelated central and autonomic portions of the nervous system.

The central nervous system embraces the brain and spinal cord with its 31 pairs of spinal nerves which handle impulses to and from muscles, skin, and the organs of hearing, smelling, seeing, touching, and tasting. Ingested alcohol depresses the central nervous system causing, among other things, impairments in judgment, perception, and self-control; and dilation of blood vessels beneath the skin producing heightened vascular tension. Initially, the resulting sensations are relaxation and well-being.

The autonomic nervous system is a motor system, automatic in nature. It is involved in the physiological functioning of blood vessels, sweat glands, skin, heart, lungs, gastrointestinal and genitourinary tracts, and the hormone secreting glands. Within the autonomic system are sympathetic and parasympathetic nerves which, generally, produce opposing or balancing effects in the body. The sympathetic nerves mobilize bodily resources that will allow for vigorous physical activity or response—e.g., increased heart rate, raised blood pressure, enlarged pupils. The parasympathetic nerves function to conserve bodily resources—e.g., heart rate is slowed, blood pressure is lowered, pupils are constricted. Alcohol and other drugs can create these same effects within the body. They are called adrenergic when they create the sympathetic effect and cholinergic when they create the parasympathetic effect. Drugs can also inhibit or stop sympathetic and parasympathetic action and even inhibit an inhibitor. Alcohol can, for instance, depress respiratory functioning, inhibit secretion of certain hormones, and slow down the absorption of some nutrients. Thus, the effects of alcohol upon the nervous system and the bodily processes it controls are highly complex and of major consequence.

As alcohol continues to circulate through the system within the bloodstream, it eventually passes through the liver where it undergoes several changes. The major known changes involved in alcohol metabolism (oxidation) are as follows:

alcohol → acetaldehyde → acetate → carbon dioxide and water

In a 150-pound individual this process takes place at the rate of approximately ¾ ounce of alcohol per hour. The effects of an average mixed drink, glass of wine, or bottle of beer (each containing ¾ ounce alcohol) will therefore take about 1 hour to wear off; two drinks, 2 hours, and so on.

Most people can drink moderately over a lifetime without ill effect. Of those who drink, however, approximately 10 percent will become physically addicted to alcohol, and many more—though not addicted—will become problem drinkers whose lives will be adversely affected by their drinking habits.

Such people are primarily educated, employable, family-centered individuals who have become dependent on alcohol as a constant source of relief and escape from tension, anxiety, and the knotty problems of day-to-day living. Many times, their increased alcohol consumption occurs so gradually and over so long a time that they scarcely realize they are becoming progressively more entrapped by their growing dependence on alcohol.

Effects on the Central Nervous System

Alcohol acts as a depressant or anesthetic on the central nervous system. Initially it seems to produce feelings of stimulation. This

occurs because alcohol interferes with the functioning of that portion of the brain which controls our inhibitions and restraints, making us feel buoyant and exhilarated.

As we continue to drink on a given occasion, the percentage of alcohol in our bloodstream continues to increase, producing reduced functioning of the various areas of the brain with corresponding effects on our judgment, emotions, behavior, and physical well-being. Typically, this occurs in the following manner (Retholtz 1972*a*):

Blood Alcohol Level*	*Area of Brain Involved and Its Effects*
.05%	Lowered efficiency of the cortex or brain covering in the uppermost part of the brain. Impairment of judgment and release of restraints and inhibitions occur, producing feelings of warmth, relaxation, and buoyancy.
.10%	Reduced operation of those areas of the brain controlling movement. Impairment of fine coordination and ability to stand or walk in a steady fashion.
.15%	Illegal level of intoxication in many States. If a person is apprehended by the police while driving in these States, he is charged with driving under the influence of alcohol.
.20%	Lowered midbrain functioning. The person feels a need to lie down; needs help to walk or dress and undress; is easily moved to tears or rage because control of emotional expression is affected.
.30%	Reduced functioning of lower portion of brain. Person becomes stuporous and he has little comprehension of what he sees or hears.
.40%–.50%	Depression of function of the entire area of perception in the base of the brain. The individual loses all feeling, becomes unconscious, and may go into shock.
.60%	Reduced operation of the medulla in the lowermost portion of the brain which controls the involuntary bodily processes such as digestion, heartbeat, breathing, and blood pressure. Death rapidly follows.

*.05% indicates ½ drop of alcohol per 1,000 drops of blood, .10% indicates 1 drop of alcohol per 1,000 of blood, and so on.

How Does Dependence Develop?

People of all races drink for many reasons: they join others in a drink at a social gathering; they may even have been advised by their

physician to drink a glass of wine in the evening to help them relax and to stimulate appetite, as is true in the case of some elderly people; they drink for reasons of religious ceremony; they have a glass of wine to complement their meals; or they drink because they like the feelings of relaxation and warmth a drink can provide after laboring through a hectic day.

Drinking problems do not usually improve by themselves. The problem does not disappear without intervention. The alcoholic must face the fact that without help his condition will only worsen. Alcohol is insidious and addictive just as hard core drugs are. Some of the warning signs to look for are listed below, each more dangerous than the one before it. Although not totally without variation, a sequence of this type generally found:

1. Drinking to relieve tension or to gain courage to face a difficult situation.
2. Increase in tolerance for alcohol. More is required to accomplish the same effect as obtained in earlier drinking.
3. Tendency to continue drinking, with difficulty in stopping after a few drinks. Drinks may be swallowed rapidly during this period.
4. Drinking instead of eating, missed appointments, being late to work, absenteeism, leaving work early.
5. Complaints of not feeling well, irritability, lassitude.
6. Lying about drinking.
7. Annoying arguments with fellow workers. Tendency to blame others for shortcomings and inefficiency.
8. Blackouts, i.e., memory lapses such as not being able to recall driving home.
9. Stealing drinks and attempts to hide it.
10. Drinking in the morning, often alone.
11. Attention wanders and lack of concentration becomes more marked.
12. Loss of interest in job and other persons.
13. Tremors following hangovers.
14. Personal crises develop such as threat of job loss or divorce.
15. More grandiosity in an effort to cover up personal failings.
16. Prolonged absences, unpredictability, drinking on the job, total undependability, paranoid ideas about others in one's life. Depression and possible suicide attempts.

Group Resources for Rehabilitation (Retholtz 1972*b*)

Alcoholics Anonymous: There is a nationwide network of these voluntary supportive groups of recovering and recovered alcoholics. The major goal of A.A. is to help members gain and maintain sobriety.

The only qualification for membership is the desire to stop drinking. Each member helps another alcoholic when called upon. Help may include being a constant companion; providing understanding and sympathetic help at any hour of the day or night; helping out with domestic, financial, or legal problems; and sometimes even inviting the alcoholic to share quarters. Alcoholics Anonymous also sponsors supportive groups for the friends and family members of alcoholics. There are no dues or fees required for membership.

Alanon: These are groups for the families and friends of alcoholics. Members learn to understand the nature of the illness of alcoholism; learn how to cope more effectively with the alcoholic and the domestic, financial, and legal problems generated by his illness; and learn about the local community resources available to help them.

Education Groups: The primary function of these groups is to teach alcoholics how to improve and maintain their mental and physical health. This information may be presented through lectures, films, or discussions led by a panel of experts, alcoholics themselves, or recovered alcoholics. Participants are acquainted with the nature of and ways in which to deal with their alcohol and alcohol-related problems, as well as the community resources that are available to assist them in this effort. The alcoholic's spouse and children may also attend the meetings. Such groups are usually provided by State, county, or private rehabilitation centers. Contact State or county health departments for information about groups that may exist in your area.

Activity Groups: These groups offer alcoholics new interests and outlets for self-expression by engaging them in such activities as fishing, organized sports, dancing, arts, crafts, photography, hiking, camping, and bridge. Psychodrama and sociodrama are employed by some groups to explore psychological and social problems. Increased self-confidence and resocialization emerge as byproducts of this therapeutic group experience. Information regarding these groups can be obtained from local A.A. headquarters or State or county health departments.

Halfway and Quarterway Houses: These facilities provide alcoholics with experiences in group living and group therapy. Many houses are managed by recovered alcoholics who serve as models of success for the others. The primary goal for all members is abstinence. After an initial drying-out period, most houses require that residents find some kind of gainful employment, share household duties, adhere to the established code of conduct, and attend A.A. meetings regularly. They are also encouraged to form their own discussion groups within the house to help each other resolve personal and group problems. Local chapters of the National Council on Alcoholism and A.A., or State or county health departments can supply you with additional information.

Therapeutic Communities: These live-in units have been established in some hospitals. They operate on an informal, socially-structured, open-door basis. Therapies include unit discussion groups, psychodrama, and social and vocational guidance both within and without the hospital setting. Some therapeutic communities have formed expatients' clubs that provide continuity of care after the person leaves the live-in unit.

Correctional Institutions: Jailing is gradually being phased out as a rehabilitative measure for chronic indigent alcoholics. Effective treatment programs are offered in some correctional facilities, however. They provide inmates with physical work therapy, educational and vocational rehabilitation, arts and crafts classes (public exhibitions of their work are often given), and participation in organized sports. Such programs also include, as basic to their goals, adequate preparation for the person's eventual release and return to society.

Released-Offender Groups: Some correctional facilities provide group therapy for their paroled and released offenders. The therapeutic gatherings may eventually evolve into Alcoholics Anonymous or Synanon groups. Many of these efforts fail unless some kind of legal compulsion exists to attend regularly, such as a requirement of parole or probation. A few of these groups have emerged within the California penal system.

Multidisciplinary Resources

Federally Administered Programs: Many Federal programs related to alcohol abuse exist within the components of the Department of Health, Education, and Welfare: the National Institute on Alcohol Abuse and Alcoholism, the National Institutes of Health, the Food and Drug Administration. Other interested agencies include the Departments of Labor, Defense, Transportation, and Housing and Urban Development. Their activities include program development, technical and professional assistance, training, and the funding of demonstration and research projects.

State Alcoholism Programs: Most States and the District of Columbia have alcoholism programs, which are usually sponsored by their health and welfare departments. These programs operate or support research, educational, and treatment facilities for alcohol abuse. Rehabilitative efforts may include medical care; psychological counseling; financial and legal assistance; and recreational, vocational, and social rehabilitation. You may receive further information by contacting your State health department.

Community Resources: These facilities are usually sponsored by State or county agencies. They provide for research, education, and treatment of alcohol problems in local hospitals and outpatient clinics.

The State or county health departments can supply more information about these resources.

Incidence and Severity of the Indian Alcohol Problem

The alcoholism death rate for the Indian and the Alaskan native during the past few years has ranged from 4.3 to 5.5 times the U.S. all-races rate. In 1971 there was an increase in the alcoholism death rate over that in 1969. Although the U.S. rate is increasing, the Indian rate is increasing faster.

Roughly two-thirds of the alcoholism deaths among the Indian population are the result of cirrhosis of the liver with associated alcoholism. Another 30 percent result from alcoholism, and the remainder are due to alcoholic psychoses.

The severity of the problem of alcoholism, alcoholic psychoses, and deaths from cirrhosis of the liver with associated alcoholism may be seen in Table VI. As one can note from the latest statistical data for 1969, the death rate in the Indian segment of our population is more than five times higher than the national average. Table VII shows the gradual increase in rates of both sexes with age, with a peak in the 35-to-44-year range and a decline thereafter. The sex ratio for simple intoxication remains relatively constant with age, at an average of 2.5/1.0, but for cirrhosis with alcoholism the sex ratio is reversed, with a ratio of 0.78/1.00. In observing the relationship among alcoholism, the Indian, and the criminal justice system, it is evident from Table V that the most common serious crime involving Indians is homicide. In addition, the arrest rate for Indians is 12 times that of the non-Indian for alcohol-related offenses. The alcoholic's life expectancy is at least 10 to 12 years less than that of the average moderate drinker or abstainer. Alcoholics frequently die in jails as the result of delirium tremens, internal bleeding, head injuries, pneumonia, or suicide.

Historically it is generally agreed that Indians north of Mexico were unaware of distilled alcoholic spirits before the arrival of the Europeans in the 16th and 17th centuries, although some evidence exists that fermented beers and wines were used in some religious rites. Since Indians had little or no contact with alcohol in beverages, they did not develop cultural means for dealing with its problems; thus their lack of ways to control drinking made them easy victims of alcohol. For thousands of years Western cultures have used alcohol for social and religious purposes and have established ways of regulating behavior more fully than has the Indian population. The lack of cultural norms has resulted in dangerous patterns of drinking among Indian groups. First, the use of alcohol as a focus for group activity has developed. A great deal of sharing of alcohol exists within Indian groups, with heavy pressure to give and accept freely from others. Many fear that if they fail to comply, they will incur

Table VI.—Alcoholism deaths and rates for Indians and Alaskan Natives in 24 reservation States and U.S., all races, per 100,000 population

	1966	*1967*	*1968*	*1969*	*1970*	*1971*
Number of deaths Indians and Alaskan Natives in 24 reservation States						
Alcoholism	55	51	91	81	NA	107
Alcoholic psychoses	5	6	10	7	NA	10
Cirrhosis of liver with mention of alcoholism	128	126	165	179	NA	217
Total	188	183	266	267		334
Alcoholism death rates Indians and Alaskan Natives in 24 reservation States						
Alcoholism	8.9	8.0	13.8	11.9	NA	14.8
Alcoholic psychoses	0.8	0.9	1.5	1.0	NA	1.4
Cirrhosis of liver with mention of alcoholism	20.7	19.7	25.0	26.3	NA	30.1
Total	30.4	28.6	40.3	39.2		46.3
Alcoholism death rates: U.S., all races						
Alcoholism	1.6	1.5	2.0	2.0		
Alcoholic psychoses	0.3	0.3	0.3	0.3		
Cirrhosis of liver with mention of alcoholism	4.8	4.8	5.0	5.2		
Total	6.7	6.6	7.3	7.5		

NA=Not available

Table VII.—Discharge rates (per thousand population) for simple intoxication and cirrhosis with alcoholism, in persons admitted to all IHS and Contract Hospitals, July 1, 1967 through June 30, 1968.

Age	*Simple intoxication*			*Cirrhosis with alcoholism*		
	M	*F*	*Total*	*M*	*F*	*Total*
0–14	0.2	*0.0	0.1			
15–19	2.4	0.9	1.6			
20–24	8.3	2.8	5.5	*0.0	*0.0	*0.0
25–34	13.7	5.5	9.5	1.4	2.6	2.0
35–44	17.2	7.0	12.1	2.9	3.6	3.2
45–54	10.0	3.9	7.1	2.4	2.6	2.5
55–64	6.3	1.7	4.1	1.8	1.7	1.8
65	2.8	1.0	2.0	0.5	0.2	0.4
All ages	5.1	2.0	3.5	0.7	0.9	0.8

*Numbers are too small for calculation of a reliable rate.
Data supplied by the Indian Health Service, Department of Health, Education, and Welfare.

social disapproval and rejection. Second, aggressive behavior often develops under the influence of alcohol. The same behavior would evoke rejection, disapproval, and punishment if the individual were not intoxicated. Large amounts of alcohol appear to produce feelings of despondency, self-hatred, fear, and violence. This may be one reason why half the people of all races who commit suicide and a third of those who lose their lives in murders have had significant amounts of alcohol in their bloodstreams at autopsy.

Unfortunately, the Indian male, like those in many other minority groups, usually works in menial, low-status jobs if he can find employment at all. He has virtually no chance to become self-assertive and experience feelings of personal worth. Moreover, conditions and attitudes prevail that make it easy for him to feel that a low-level of performance is expected and that he is presumed to be irresponsible and unreliable. As a result, there are few avenues open for feeling self-worth other than gaining acceptance through fellowship in a drinking group. Available jobs are fewer once an individual becomes an alcoholic and gets to be known as such, and his income is lower if he does find work. Job security is extremely uncertain and frequently work is only temporary. In many instances there appears to be little advantage in working as opposed to obtaining welfare assistance; in point of fact, the receipt of welfare money can be an even more reliable source of income than working. When new industries are established on reservations they often employ only women; the men are thus left at home, which adds to feelings of emasculation and lack of responsibility as a family leader. Even when men are employed, they may be required to work at the same jobs as women, which contributes to lack of self-esteem, annoyance, animosity, disgust, and self-hatred. Women

too are subjected to many stressful situations, including being the recipients of abuse from alcoholic husbands. By and large, women are less likely to develop alcoholism than men in most Indian communities for the reasons outlined above. Suicidal attempts are frequent among Indian women, however. When they move to cities, Indians feel detached from the security of their own surroundings, and removed from their relatives and friends, and frequently do not adapt well to urban living as it is now constituted for them. Many will return home discouraged, while others may drift from one slum to another in a large city. The result is an increase in the likelihood of drinking (and more recently drug abuse), with suicide and homicide as potential outcomes.

In one Indian community in the Northwest, records were kept during fiscal year 1968 showing accidents related to drinking (Bopp 1968). Eighty percent of the auto accidents, 31 percent of accidental injuries, 94 percent of the fights involving injury, and all 35 suicide attempts were shown to be related to drinking. The Indian Health Service staff believes these figures to be conservative. A study in a Southwestern Indian tribe showed that 4 percent of suicides involved intoxication at the time of or just before the act occurred (Levy 1965). It has been shown that 43 percent of all arrests in the United States were related to drinking but the comparable figure for Indians was 76 percent (Stewart 1964). Drunkenness alone accounted for 71 percent of total Indian arrests. Nonalcoholic arrests were only slightly above the U.S. average. In a State penitentiary Indians comprised 34 percent of the inmate population, although in the total State census they comprised only 5 percent of the population (Baker 1959). The majority of crimes were committed while under the influence of alcohol. The problem has existed for a number of years, as is shown by the fact that as far back as 1959, all 36 Indian prisoners in one Federal prison had been convicted of murder or manslaughter while intoxicated (Baker 1959).

Alcoholism Among Young People

The increasing severity of the problem of alcoholism and emotional disturbance among young Indians is apparent. In 1968, 1,769 arrests resulted from excessive drinking in one northern plains reservation, with 10 percent involving the juvenile population (Indian Health Service 1967).

One may observe in Table VII the high discharge rates among persons admitted for simple intoxication and cirrhosis of the liver resulting from alcoholism to all Indian Health Service and contract hospitals. A gradual increase in rates with age may be seen for both sexes; the greatest number occurs between 35 and 44, and thereafter there is a gradual decline. The sex ratio for simple intoxication has remained constant with age at an average of 2.55 per 1.00, whereas

the existence of cirrhosis of liver with alcoholism for the overall sex ratios is shown to be a reciprocal of 0.78 per 1.00.

Among the 15–17-year age group, 50 percent in one central plains reservation said they drank. Sixty percent of the boys and 40 percent of the girls were drinkers. This behavior started early, between the ages of 9 and 17, with the average age being 15.5 years. Of those under 17 years of age, 88 percent stated that most of their friends drank. Thirty-one percent of the total sample were abstainers, 45 percent drank less often than three times per week, and 24 percent drank more than three times per week. Evidence indicated that both sexes from this generation, particularly women, drank more than the previous one. In a study of high school students in a plains tribe, 84 percent of the boys and 76 percent of the girls stated that they drank (Whittaker 1962).

While one must generalize with caution, persistent drinking patterns have been shown in data that seem relatively consistent. Drinking is clearly pervasive and it is most prevalent among young Indians in the 25-to-44-year age range. Male drinkers ordinarily outnumber females by at least 3 to 1. Most youths of both sexes have tried alcohol and may be regular drinkers by the age of 15. After the age of 40, there appears to be some decline in alcohol consumption, although in many instances damage has already occurred.

Causes of Suicides Related to Alcoholism

Social factors contributing to suicide and alcoholism consist of cultural identity conflicts, loss of tradition and heritage, prejudice and discrimination, movement away from spiritual interests, and peer group pressures among adolescents.

Political factors include government paternalism and suppression by a dominant society. Such factors inhibit Indian self-expression, decision-making, and control of individual destiny.

Situational factors are contained for the most part in those aspects of the suicide profile noted previously. Time and frequency spent in boarding schools and disrupted family units are particularly relevant.

In relation to education, 10 percent of all American Indians above 14 years of age have no schooling at all. Nearly 60 percent have less than an eighth-grade education. Problems of Indians attending school include language barriers, isolation in remote areas, and lack of a tradition of academic achievement. Forty-two percent of Indian children, almost twice the national average, drop out before completing high school (Chumbley 1973).

In schools, Indians are subjected to a curriculum based on non-Indian educational materials. They find it difficult to identify with Anglo middle-class values. Their textbooks project cultural stigmas,

as in stories of the cavalry and the Indians. There are few books written by Indians for Indian children.

The educational environment plays a major role in suicide among young Indians. Blocked educational opportunities; lack of exposure to extracurricular activities such as sports and interest groups; older non-Indian teachers lacking interest and innovation; little change in curriculum over time; students coming from far distances separated from friends and relatives; and restriction of freedom—all contribute to the suicide and alcoholism problem among young Indians at boarding schools.

We must view the suicides and the alcoholism problem of the American Indian as symptoms of a severe and often fatal disturbance. In attempting to provide solutions we must become cognizant of the clues that are frequently present, for they are more than merely clues—*they are cries for help.* We must alert ourselves to the causes and contributing factors such as unemployment, inadequate housing, blocked educational opportunities, cultural conflicts, and loss of identity. These are the roots of the frustration that manifests itself in drinking and self-destruction.

Where can the answers be found? The answers lie within the Indian people themselves. American Indians want to realize their *personal potential* by controlling their own future, making their own decisions, and involving Indian people in the implementation of these decisions. Every minority group destined to progress must reach this state of responsibility to renew and maintain cultural pride in its heritage, as well as promote individual self-esteem and motivation to succeed. Only by working together to develop themselves and their environment can the American Indians hope to solve these devastating social problems and restore a new dignity to their people, for they, like all human beings, must have *something to live for.*

Recommendations for the Future

1. Regular workshops should be held at least yearly for all those who work with the Indian people, including Indians themselves. It is vitally important to continue didactic meetings whereby additional knowledge can be disseminated and shared, difficult cases can be discussed, poignant and unique cultural and tribal information can be utilized, and resource persons can assist in recommendations for improved program development. Regional seminars or workshops should be held in addition to meetings at the national level to include the entire United States.
2. A nationwide coordinating office or desk should be established to collate and disseminate information, provide training and research grant consultation and technical assistance, arrange meetings and

workshops, develop educational material, and visit regional programs regularly. This office should be developed at the Federal Government level within one of the existing agencies such as the NIMH or IHS.

3. Educational and instructional programs should be developed for teachers. It will be helpful, in preventing tomorrow's mental health problems, to involve both school teachers and students. Material should be programmed at the level of the student as well as the teacher to promote mental hygiene and crisis intervention concepts.
4. Law Enforcement personnel should have a separate and continuing program of instruction in crisis intervention and psychological information. Causes; primary, secondary, and tertiary prevention principles; and treatment methods should be a part of the working knowledge of such persons. Information about what to do and what not to do and when and how to utilize referral resources should be included. Basic knowledge concerning alcoholism and suicide should be the cornerstones of this program.
5. A newsletter or leaflet should be developed and distributed regularly. This would help keep those on the reservations current about important concepts and developments between and during yearly workshop meetings. Workshop information should be compiled and distributed as part of the newsletter or leaflet program.
6. Audiovisual information should be developed, cataloged, and distributed for purposes of instruction and program development. Films, videotapes and recordings of projects in the field as well as important documentary pieces historically in the health field among various Indian cultures would be invaluable for learning purposes.

APPENDIX A

Population Data on American Indians and Alaskan Natives From the 1960 and 1970 Censuses

By State

State	1960 Census	1970 Census(a) (first count)	Ten-year increase	Percent increase
Alabama	1,276	2,514	1,238	49%
Alaska	42,522	51,528	9,006	21
Arizona	83,387	95,812	12,425	15
Arkansas	580	2,041	1,461	253
California	39,014	91,018	52,004	133
Colorado	4,288	8,836	4,548	106
Connecticut	923	2,222	1,299	140
Delaware	597	656	59	10
District of Columbia	587	956	369	63
Florida	2,504	6,719	4,215	168
Georgia	749	2,455	1,706	228
Hawaii	472	1,126	654	136
Idaho	5,231	6,687	1,456	28
Illinois	4,704	11,413	6,709	143
Indiana	948	3,887	2,939	310
Iowa	1,708	2,992	1,284	75
Kansas	5,069	8,672	3,603	71
Kentucky	391	1,599	1,208	309
Louisiana	3,587	5,366	1,779	49
Maine	1,879	2,195	316	17
Maryland	1,538	4,258	2,720	178
Massachusetts	2,118	4,475	2,357	111
Michigan	9,701	16,854	7,153	74
Minnesota	15,496	23,128	7,632	49
Mississippi	3,119	4,113	994	32
Missouri	1,723	5,405	3,682	224
Montana	21,181	27,130	5,949	28
Nebraska	5,545	6,624	1,079	20
Nevada	6,681	7,933	1,252	19
New Hampshire	135	361	226	167
New Jersey	1,699	4,706	3,007	183
New Mexico	56,255	72,788	16,533	29
New York	16,491	28,330	11,839	72
North Carolina	38,129	43,487	5,358	14
North Dakota	11,736	14,369	2,633	22
Ohio	1,910	6,654	4,744	248
Oklahoma	64,689	97,731	33,042	51
Oregon	8,026	13,510	5,484	68
Pennsylvania	2,122	5,533	3,411	160
Rhode Island	932	1,390	458	49
South Carolina	1,098	2,241	1,143	105
South Dakota	25,794	32,365	6,571	26
Tennessee	638	2,376	1,738	272
Texas	5,750	18,132	12,382	214
Utah	6,961	11,273	4,312	62
Vermont	57	229	172	310
Virginia	2,155	4,904	2,749	128
Washington	21,076	33,386	12,310	58
West Virginia	181	808	627	346
Wisconsin	14,297	18,924	4,627	32
Wyoming	4,020	4,980	960	24
Total, Indians And Alaska Natives	551,669	827,091	275,422	50%
Total, General Population (Including Indians And Alaska Natives)	179,323,175	203,184,772	23,861,597	13

(a) Source: Unpublished data from the 1970 Census, supplied to the Bureau of Indian Affairs, Statistics Branch, by the Bureau of the Census.

APPENDIX B

Community Mental Health Centers Serving Indian and Alaskan Natives

Reservation	Center
ALASKA	
(Alaskan Natives)	Gateway MHC 628 Park Avenue (P.O. Box 291) Ketchikan 99901
	*Kodiak Island Borough MHC P.O. Box 712 Kodiak 99615
ARIZONA	
Navajo Hopi Hualpai Kaibab Fort Mohave Fort Apache	Northern Arizona CMHC 2725 East Lakin Drive Flagstaff 86001
San Xavier San Carlos Papago	Tucson South MHC Saint Mary's Hospital P.O. Box 5614 Tucson 85703
Fort McDowell Gila River Papago Salt River	Arizona Foundation MHC 5055 North 34th Street Phoenix 85018
	Jane Wayland Child Guidance Center 1937 West Jefferson Street Phoenix 85009
	*St. Joseph's Hospital MHC 350 West Thomas Road Phoenix 85013
CALIFORNIA	
Colorado River	Hemet Valley Hospital District CMHC 1116 East Latham Avenue Hemet 92343
Tule River	Kings View Hospital CMHC 42675 Road 44 Reedley 93654
IDAHO	
Fort Hall	Gateway CMHC 1553 East Center Street Pocatello 83201
Nez Perce	White Pine 312 - 6th Street Lewiston 83501
Coeur D'Alene	*Panhandle MHC Coeur D'Alene 83814
MAINE	
Penobscot Indian Township Passamaquoddy Pleasant Point Passamaquoddy	The Counseling Center 43 Illinois Avenue Bangor 04401
MINNESOTA	
White Earth	Northwestern MHC 120 LaBree Avenue South Thief River Falls 56701
Fond du Lac Nett Lake Vermillion Lake	Range MHC, Inc. 624 - 13th Street Virginia 55792
MONTANA	
Crow	Comprehensive CMHC 1245 North 29th Billings 59102
Fort Peck Fort Belknap Northern Cheyenne	Eastern Montana Region 5 MHC 502 - 2nd Street South Glasgow 59230
Flathead	Western Montana Regional CMHC 2829 Fort Missoula Road Missoula 59801
Blackfeet Fort Belknap Northern Cheyenne Rocky Boy	*Region II MHC Northern Montana Hospital Havre 59501
NEW MEXICO	
Canoncito Navajo Isleta Laguna Sandia	Bernalillo County MHC 2600 Marble Avenue, NE. Albuquerque 87106
NORTH CAROLINA	
Cherokee	Western Carolina College MHC P.O. Box 2784 Cullowhee 28723
NORTH DAKOTA	
Fort Berthold Standing Rock	Memorial MH & MR Center 1007 18th Street NW. Mandan 58554
Fort Berthold	North Central MH & Retardation Center 17 West Central Avenue Minot 58701
Fort Totten	Northeast Region MH & Retardation Center 509 South Third Street Grand Forks 58201
Sisseton	Southeast Region MH & Retardation Services Center P.O. Box 2013 700 1st Avenue South Fargo 58102

APPENDIX B—Continued

Reservation	Center
SOUTH DAKOTA	
Flandreau	*McKennan Hospital MHC 800 East 21st Street Sioux Falls 57105
UTAH	
Uintah & Ouray	Timpanogas CMHC 300 North 1100 East Provo 84601
WASHINGTON	
Makah	*The Olympic Center for MH & MR P.O. Box 4099, Wycoff Station Bremerton 98310
Quinault	
Muckleshoot	Harborview CMHC 925 Terrace Street Seattle 98104
Lummi	*Outpatient Clinic & Psychiatric Day Center 401 Harris Avenue Bellingham 98225
WISCONSIN	
Oneida	Brown County Hospital CMHC 1320 Mahon Avenue Green Bay 54301

*Not in operation as of August 1971.

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